To be or not to be LGBT in primary health care:

health care for lesbian, gay, bisexual, and transgender people

Lesbian, gay, bisexual, and transgender (LGBT) health care will, increasingly, be a feature of the primary care repertoire.[1] Pride in Practice, which is supported by the Royal College of General Practitioners, provides a rating system that judges primary care surgeries on a welcoming environment, access, the GP, patient consultation, staff awareness and training, and health promotion for LGBT people. For those surgeries signed up to the initiative, plans to address shortfalls will be developed in consultation with the Lesbian and Gay Foundation. Another initiative, Transgender Awareness, is attempting to address matters that are important to a diverse group of transgender patients. While acknowledging these very positive developments, it is important to understand what we mean by 'LGBT primary health care'. We will draw on the concept of LGBT health care to explore the benefits and potential harms that this term can engender, and on the different ways that the relatively sparse LGBT health literature has addressed and accounted for the different foci of LGBT health care over the years. In doing so, we will argue for a more nuanced approach to primary health care for these groups.

Student teaching has tended to position heterosexuality and gender normativity — people conforming to social standards of what is 'appropriate' feminine and masculine behaviour — as the primary context in which health and illness is viewed. Models of health care that promote these views of sexuality and gender identity over others can create an environment in which gender stereotypes and heteronormativity — the cultural bias in favour of opposite-sex over same-sex sexual relationships — result in LGBT people becoming 'add ins',[2] if and when they are considered at all. Even the term LGBT assumes that transgender patients have coextensive healthcare issues with those who are lesbian, gay, or bisexual, and can be taught together as an extension of the same theme. While sometimes there will be transgender people who identify with an lesbian, gay, or bisexual sexuality there is no intrinsic connection. It is important to respond to the requirements of lesbian, gay, bisexual, and transgender populations accessing primary care with different models, not in the form of mainstream tolerance, but changing social institutions in lasting ways.[3] Obstacles to this include the lack of time and resources[4] and the willingness and ability of faculty to teach LGBT-related curricular content.[5] There is very little medical education about LGBT issues in terms of health promotion, prevention, and care at a strategic or operational level. Education is crucial to transforming primary care for LGBT communities but must not pathologise them by situating their associated health problems as purely LGBT health issues.

The renewed emphasis on primary health care for LGBT health care, seeks to 'mainstream' these individuals as health citizens. By assuming and empowering a marginal position in social and health care, such groups are interested in mobilising resistance against a health system that has previously rendered them invisible. The gains by activists, such as the depathologising of homosexuality in the 1970s, the promotion of healthy 'gay lifestyles' in the 'safe sex' 'AIDS era', supplementary healthcare provision by LGBT community groups such as the Terrence Higgin's Trust and MESMAC ('MEn who have Sex with Men — Action in the Community'), and Press for Change and other transgender groups who have campaigned for recognition and equitable health care from the 1980s onwards, along with more positive media exposure, has resulted in a more 'tolerant' society and enabled different LGBT patient groups to highlight health inequalities and disparities. These patients and practitioners espouse principles based on an individual's entitlement to a competent health system without fear of mistreatment, neglect, and stigma,[6] regardless of sexual orientation and gender identity. These principles are fundamental to good medical practice, but do not consider the different medicolegal rights and responsibilities that heterosexual, homosexual, and transgender patients have.

As a result, policy and legal edicts specifically for LGBT people have become important factors in establishing equal rights within primary health care. The Sexual Orientation and Gender Identity Advisory Group assisted the Department of Health with the development of policies that would give guidance to clinicians in the task of reducing health inequalities, providing better employment for LGBT healthcare staff, improving services, and promoting transgender health care. Although there has been a greater recognition by the medical community of the health needs of LGBT people, this has also drawn attention to a number of less than satisfactory approaches to LGBT primary health care. Policy does not automatically translate into practice: lack of knowledge and understanding and sometimes prejudice surrounding LGBT patients continue to be major obstacles. For instance, in a recent European study about transgender health care,[7] one-third of the responders stated that they were refused treatments for gender dysphoria — the sense that your anatomical sex does not match your gender identity — because their primary care practitioner did not approve of gender reassignment. Healthcare professionals have also admitted to being homophobic[8] and 20% of therapists have reported having assisted at least one patient to access 'reparative therapy' to reduce or change their homosexual feelings.[9] Moreover, very

> *"Most of the small amount of research there is on LGBT people has focused on issues such as mental health problems ... These foci illustrate healthcare issues that require attention for some LGBT patients, but, through a process of homogenisation, also seem to pathologise and stereotype whole communities. This is because of the relatively minute window within which LGBT health care is framed."*

> *"It does appear that a supportive health system environment for LGBT health care, research, and policy is developing in the UK. A positive approach to clinical practice and research in this area could really improve health care for these patients."*

little is known about how clinicians deal with LGBT healthcare issues that they must encounter on a day-to-day basis. Whether and to what extent such healthcare issues are similar to heterosexual patients or particular to LGBT patients is under-researched.

Most of the small amount of research there is on LGBT people has focused on issues such as mental health problems that they suffer vis a vis heterosexual people,[10] risk-taking especially with their sexual health and more specifically with HIV,[11] as well as outcomes of surgical and hormonal transgender health interventions. These foci illustrate healthcare issues that require attention for some LGBT patients, but, through a process of homogenisation, can inadvertently pathologise and stereotype whole LGBT communities.[12] This is because of the relatively minute window within which LGBT health care is framed. While attempting to address disparities and generalise healthcare responses to wider LGBT populations, using the abstract variables of 'sexuality' or 'gender identity' as ubiquitously important, the aggregation of LGBT communities tends to minimise the heterogeneity of lesbian, gay men, bisexual, and transgender people, their health issues, and diverse care requirements. At the same time, this heterogeneity undermines the coherence of the concept of 'LGBT health care'. Instead of elevating lesbian, gay, bisexual, or transgender as the most salient aspect of their lives, a focus on the intersectional nature of LGBT communities, which would include how different classes, ages, ethnicities, (dis)abilities, and particular bodies intersect with sexualities and non-normative gender identities, will not only widen the scope of discussion of health issues within these communities but also has the potential to generate more robust medical research and promote better evidence-based medicine. Thus care practices must be based upon evidence-based research with a greater emphasis on the wider issues of difference within LGBT communities in order to provide a more complex picture of their health issues and disparities. Primary care research and practice is well placed in this regard because of its traditionally person-centred, individually focused, and holistic approach.

It does appear that a supportive health system environment for LGBT health care, research, and policy is developing in the UK. A positive approach to clinical practice and research in this area could really improve health care for these patients. However, we must be aware of the potential of particularising and subsequently homogenising 'LGBT primary healthcare' issues without due consideration of factors other than sexuality or non-normative gender identity that may impact on (ill)health, because this could unwittingly create new forms of healthcare stereotyping for an already 'othered,' stigmatised, and neglected group of citizens.

Zowie Davy,
Lecturer in Community Care, University of Lincoln, School of Health and Social Care, Brayford Pool, Lincoln.

A Niroshan Siriwardena,
Professor of Primary and Prehospital Health Care, University of Lincoln, School of Health and Social Care, Brayford Pool, Lincoln.

Provenance
Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp12X654731

ADDRESS FOR CORRESPONDENCE

Zowie Davy
University of Lincoln, School of Health and Social Care, Brayford Pool, Lincoln, LN6 7TS, UK.

E-mail: zdavy@lincoln.ac.uk

REFERENCES

1. The Lesbian & Gay Foundation. *Pride in practice: excellence in lesbian, gay, and bisexual healthcare*. London: NHS, 2011.
2. Hicks S, Watson K. Desire lines: 'queering' health and social welfare. *Sociol Res Online* 2003; **8(1)**.
3. Vaid U. *Virtual equality: the mainstreaming of gay and lesbian liberation*. New York, NY: Anchor Books, 1995.
4. Obedin-Maliver J, Goldsmith ES, Stewart L, *et al*. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA* 2011; **306(9):** 971–977.
5. Frenk J, Chen L, Bhutta ZA, *et al*. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010; **376(9756):** 1923–1958.
6. Safford L. New paradigm for lesbian, gay, bisexual, and transgender health. *JGLMA* 2002; **6(2):** 39–40.
7. Whittle S, Turner L, Combs R, Rhodes S. *Transgender EuroStudy: legal survey and focus on the transgender experience of health care*. Brussels: ILGA Europe and TransGender Europe, 2008.
8. Hayes JA, Erkis AJ. Therapist homophobia, client sexual orientation, and source of client HIV infection as predictors of therapist reactions to clients with HIV. *J Couns Psychol* 2000; **47(1):** 71.
9. Bartlett A, Smith G, King M. The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation. *BMC Psychiatry* 2009; **9(1):** 11.
10. Warner J, McKeown E, Griffin M, *et al*. Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. *Br J Psychiatry* 2004; **185(6):** 479–485.
11. Elam G, Macdonald N, Hickson FCI, *et al*. Risky sexual behaviour in context: qualitative results from an investigation into risk factors for seroconversion among gay men who test for HIV. *Sex Transm Infect* 2008; **84(6):** 473–477.
12. Hillier L, Edwards J, Riggs DW. Mental health and LGBT communities. *Gay and Lesbian Issues and Psychology* 2008; **4(2):** 65-68.